Oncology Coding Update 2018

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The 2018 Medicare final regulations, code updates, and other reimbursement changes will bring significant compensation shifts for oncology providers. As usual, healthcare providers will need to update their respective chargemasters, fee schedules, and other documents to ensure compliance with coding and billing guidelines.

New and Revised Procedure Codes

Each year there are new codes, revised codes, and updates to coding guidelines. For calendar year (CY) 2018, the following new procedure codes affecting oncology practices have been released:

- **+19294:** Preparation of tumor cavity, with placement of a radiation therapy applicator for intraoperative radiation therapy (IORT) concurrent with partial mastectomy (List separately in addition to code for primary procedure).
- **93792:** Patient/caregiver training for initiation of home international normalized ratio (INR) monitoring under the direction of a physician or other qualified non-physician professional, face-to-face, including use and care of the INR monitor, obtaining blood sample, instructions for reporting home INR test results, and documentation of patient's/caregiver's ability to perform testing and report results.
- **93793:** Anticoagulant management for a patient taking warfarin, must include review and interpretation of a new home, office or lab INR test result, patient instructions, dosage adjustment (as needed), and scheduling of additional test(s), when performed.

In addition, the section for bone marrow biopsy and aspiration has been revised, including the addition of three new procedure codes for CY 2018:

- **38220:** Diagnostic bone marrow; aspiration(s).
- **38221:** Diagnostic bone marrow; biopsy(ies).
- **38222:** Diagnostic bone marrow biopsy(ies) and aspiration(s).

Effective Jan. 1, 2018, the following HCPCS procedure code has been deleted: **G0364:** Bone marrow aspiration performed with bone marrow biopsy through the same incision on the same date of service.

Temporary Category III code 0438T will be replaced with new CPT® code **55874:** Transperineal placement of biodegradabe material, peri-prostatic, single or multiple injection(s), including image guidance, when performed.

The following procedure codes have undergone a change in descriptor for CY 2018:

- **32998:** Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; radiofrequency.
- **76000:** Fluoroscopy (separate procedure), up to 1 hour physician or other qualified healthcare professional time.

Last, the following procedure codes have been deleted for CY 2018:

- **77422:** High energy neutron radiation treatment delivery; single treatment area using a single port or parallel-opposed ports with no blocks or simple blocking.
- **0301T:** Destruction/reduction of malignant breast tumor with externally applied focused microwave, including interstitial placement of disposable catheter with combined temperature monitoring probe and microwave focusing sensocatheter under ultrasound thermotherapy guidance.
- **0438T:** Transperineal placement of biodegradable material, peri-prostatic (via needle), single or multiple, includes image guidance.

HCPCS Level II Modifier Updates

In addition to changes in procedure codes, there are new and updated HCPCS modifiers, some of which are discussed in more detail in other sections of this article. Modifier CP (Adjunctive service related to a procedure assigned to a comprehensive ambulatory payment classification [C-APC] procedure, but reported on a different claim) is the only oncology-related HCPCS modifier deleted for CY 2018.

As a result of changes to the 340B Drug Pricing Program, the following modifiers have been created for CY 2018:

- **JG:** Drug or biological acquired with 340B Drug Pricing Program discount.
- **TB:** Drug or biological acquired with 340B Drug Pricing Program discount, reported for informational purposes.

The following modifier was created for imaging providers to use on a voluntary basis starting July 1, 2018, to show that the ordering professional consulted Appropriate Use Criteria (AUC) for advanced diagnostic imaging (CT, MRI, PET, other nuclear medicine): **QQ:** Ordering professional consulted a qualified clinical decision support mechanism for this service and the related data was provided to the furnishing professional.

New modifiers have been created for reporting patient relationship categories as required by MACRA, effective Jan. 1, 2018, on a voluntary basis:

- **X1:** Continuous/broad services: for reporting services by clinicians, who provide the principal care for a patient, with no planned endpoint of the relationship; services in this category represent comprehensive care, dealing with the entire scope of patient problems, either directly or in a care coordination role; reporting clinician service examples include, but are not limited to: primary care, and clinicians providing comprehensive care to patients in addition to specialty care.
- **X2:** Continuous/focused services: for reporting services by clinicians whose expertise is needed for the ongoing management of a chronic disease or a condition that needs to be managed and followed with no planned endpoint to the relationship; reporting clinician service examples include but are not limited to: a rheumatologist taking care of the patient's rheumatoid arthritis longitudinally but not providing general primary care services.
- **X3:** Episodic/broad services: for reporting services by clinicians who have broad responsibility for the comprehensive needs of the patient that is limited to a defined period and circumstance such as a hospitalization; reporting clinician service examples include but are not limited to the hospitalist's services rendered providing comprehensive and general care to a patient while admitted to the hospital.
- **X4:** Episodic/focused services: for reporting services by clinicians who provide focused care on particular types of treatment limited to a defined period and circumstance; the patient has a problem, acute or chronic, that will be treated with surgery, radiation, or some other type of generally time-limited intervention; reporting clinician service examples include but are not limited to, the orthopedic surgeon performing a knee replacement and seeing the patient through the postoperative period.
- **X5:** Diagnostic services requested by another clinician: for reporting services by a clinician who furnishes care to the patient only as requested by another clinician or subsequent and related services requested by another clinician; this modifier is reported for patient relationships that may not be adequately captured by the above alternative categories; reporting clinician service examples include but are not limited to, the radiologist's interpretation of an imaging study requested by another clinician.

Longstanding modifiers **Q5** and **Q6** were revised effective July 1, 2017, to show that they can be used for substitute physical therapists in HPSAs (health professional storage areas). Also, CMS has substituted the term "fee for time" for "locum tenens":

- **Q5:** Service furnished under a reciprocal billing arrangement by a substitute physician or by a substitute physical therapist furnishing outpatient physical therapy services in a health professional shortage area, a medically underserved area, or a rural area.
- **Q6:** Service furnished under a fee-for-time compensation arrangement by a substitute physician or by a substitute physical therapist furnishing outpatient physical therapy services in a health professional shortage area, a medically underserved area, or a rural area.

Drug Codes

One drug code has been discontinued as of Dec. 31, 2017 (refer to new drug codes **J1726** and **J1729** for coding options): **J1725:** Injection, hydroxyprogesterone caproate, 1 mg.

In addition, the following code has been discontinued effective Dec. 31, 2017, **A9599**: Radiopharmaceutical, diagnostic, for beta amyloid positron emission tomography (PET) imaging, per study dose, not otherwise specified.

The Q-codes for pathogen-reduced platelets have been replaced with P-codes. Specifically, **Q9987:** Pathogen(s) test for platelets has been replaced with **P9100:** Pathogen(s) test for platelets, and **Q9988:** Platelets, pheresis, pathogen-reduced, each unit has been replaced with **P9100:** Pathogen(s) test for platelets.

In addition, HCPCS code **P9072:** Platelets, pheresis, pathogen-reduced or rapid bacterial tested, each unit is deleted effective Dec. 31, 2017.

Effective Jan. 1, 2018, there are new codes, revised codes, and replaced codes for drugs, biologicals and substances. Following are new drug HCPCS codes:

- **C9014:** Injection, cerliponase alfa, 1 mg.
- **C9015:** Injection, C-1 esterase inhibitor (human), Haegarda, 10 units.
- **C9016:** Injection, triptorelin extended release, 3.75 mg.
- **C9024:** Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine.
- **C9028:** Injection, inotuzumab ozogamicin, 0.1 mg.
- **C9029:** Injection, guselkumab, 1 mg.
- **J0604:** Cinacalcet, oral, 1 mg, (for ESRD on dialysis).
- **J0606:** Injection, etelcalcetide, 0.1 mg.
- **J1555:** Injection, immune globulin (Cuvitru), 100 mg.
- **J7211:** Injection, factor VIII, (antihemophilic factor, recombinant), (Kovaltry), 1 IU.
- **J7345:** Aminolevulinic acid HCl for topical administration, 10% gel, 10 mg.
- **Q2040:** Tisagenlecleucel, up to 250 million CAR-positive viable T cells, including leukapheresis and dose preparation procedures, per infusion.

At the request of the American Society of Addiction Medicine, the Centers for Medicare & Medicaid Services (CMS) created three new codes for insertion and removal of subdermal buprenorphine implants for opioid addiction:

- **G0516:** Insertion of non-biodegradable drug delivery implants, 4 or more (services for subdermal rod implant).
- **G0517:** Removal of non-biodegradable drug delivery implants, 4 or more (services for subdermal implants).
- **G0518:** Removal with reinsertion, non-biodegradable drug delivery implants, 4 or more (services for subdermal implants).

Table 1, below, lists drugs that have been assigned new J-codes, effective Jan. 1, 2018.

Table 1. Drugs Assigned New J-Codes in 2018 Cross-Walked with the Deleted C-Codes

NEW 2018 CODE		DELETED 2017 CODE	
J0565	Injection, bezlotoxumab, 10 mg.	**C9490**	Injection, bezlotoxumab, 10 mg.
J1428	Injection, eteplirsen, 10 mg.	**C9484**	Injection, eteplirsen, 10 mg.
J1627	Injection, granisetron, extended-release, 0.1 mg.	**C9486**	Injection, granisetron extended release, 0.1 mg.
J1726	Injection, hydroxyprogesterone caproate, (Makena), 10 mg.	**Q9986**	Injection, hydroxyprogesterone caproate, (Makena), 10 mg.
J1729	Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg.	**Q9985**	Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg.
J2326	Injection, nusinersen, 0.1 mg.	**C9489**	Injection, nusinersen, 0.1 mg.
J2350	Injection, ocrelizumab, 1 mg.	**C9494**	Injection, ocrelizumab, 1 mg.
J3358	Ustekinumab, for intravenous injection, 1 mg.	**Q9989**	Ustekinumab, for intravenous injection, 1 mg.
J7210	Injection, factor VIII, (antihemophilic factor, recombinant), (Afstyla), 1 IU	**C9140**	Injection, factor VIII (antihemophilic factor, recombinant) (Afstyla), 1 IU
J7296	Levonorgestrel-releasing intrauterine contraceptive system, (Kyleena), 19.5 mg.	**Q9984**	Levonorgestrel-releasing intrauterine contraceptive system (Kyleena), 19.5 mg.
J9022	Injection, atezolizumab, 10 mg.	**C9483**	Injection, atezolizumab, 10 mg.
J9023	Injection, avelumab, 10 mg.	**C9491**	Injection, avelumab, 10 mg.
J9203	Injection, gemtuzumab ozogamicin, 0.1 mg.	**J9300**	Injection, gemtuzumab ozogamicin, 5 mg.
J9285	Injection, olaratumab, 10 mg.	**C9485**	Injection, olaratumab, 10 mg.